Illinois Department of Public Aid

no. : 1-2003

# ILLINOIS MEDICAL ASSISTANCE PROGRAM
# PROVIDER BULLETIN

02/19/03

To: Providers of Long Term Care (SNF/ICF)

RE: Handbook Update - Annual Resident Review

This handbook update notifies providers that Annual Resident Reviews (AARs) are no longer conducted in nursing facilities (NFs) that have individuals with developmental disabilities and mental illness .

The requirement for ARRs is being removed in order to comply with Public Law 104-315. P.L. 104-315 replaced ARR with a notification of significant change notification. The significant change language will be inserted into the handbook upon adoption of the rule.

This update also clarifies which residents are included in the Inspection of Care survey.

HANDBOOK REVISIONS

Remove pages i/ii, 35/36, 37 and Appendix C-10 and replace with the attached pages.

**ILLINOIS DEPARTMENT OF PUBLIC AID**

SECTION

II

CHAPTER C-200

Long Term Care Facility Services

## C-216 Retention of Recipients/Applicants Following Hospitalization

A long term care facility must accept a Public Aid applicant or resident back into the facility when the hospital staff has determined that the individual's medical condition enables him/her to return to the facility within 10 days. The applicant or resident is considered a resident of a long term care facility during any hospital stay totaling 10 days or less.

The Department may recover its costs from the facility for unnecessary hospitalization if:

- a facility refuses to accept the resident back into the facility following a hospital stay of 10 days or less and
- the Department becomes liable for hospital bills incurred due to the facility's refusal to accept the individual back into a facility.

If a resident remains unnecessarily hospitalized for one or more days, the Department will pay the hospital and the facility owes the Department the difference between the hospital's per diem rate and the facility's per diem rate.

A long term care resident may be involuntarily transferred or discharged from a facility for only the following reasons:

- for medical reasons,
- for the resident's safety,
- for the physical safety of other residents, the facility staff or facility visitors, or
- for non-payment of resident's stay. This does not apply to those residents whose care is provided for under the Illinois Public Aid Code.

Before a long term care resident can be involuntarily transferred or discharged from a Medicaid certified facility, the resident or resident's guardian or representative must be given 30 days advance written notice of his/her right to request a hearing from the Illinois Department of Public Health over the question of whether or not the resident must cease living in that facility.

C-217 Inspection of Care (IOC)

An Inspection of Care survey of services received by Medicaid residents in each long term care facility will be conducted at least annually. The survey is a resident-specific quality assurance evaluation to ensure that each Medicaid resident is provided with a range and quality of medical and nursing management and social services that is necessary and commensurate with his/her physical needs and optimum functioning. It also assesses the methods by which a facility complies with the utilization control requirements of physician certification, admission evaluation, plan of care, and discharge planning.

In accordance with the Department's reimbursement system, an IOC is conducted at least annually in SNF and ICF facilities as a means of setting the nursing component of the facility's daily rate.

= All residents who are Medicaid eligible (with a Recipient Identification Number)as of the day before the IOC assessment begins will be included in the IOC and rate setting calculation. This does not include residents who die or are discharged or become Medicaid ineligible prior to the nurse completing the IOC Form 2700 (See Appendix C-7). It will include residents who have died, been discharged, or become Medicaid ineligible after the IOC assessment has been completed, but prior to the rate calculation and those residents who are Medicare/Medicaid dually eligible. Providers will be able to present proof of Medicaid eligibility and qualify a resident to be included in the IOC until the day of the exit conference of the IOC. However, the resident must have been Medicaid eligible on the day before the IOC began.

For any area of the IOC rated "Needs Not Met", the facility shall explain the corrective action to be taken. These actions shall be listed on form DPA 2933, Inspection of Care (IOC) Facility Response (see Appendix C-16).

=C-217.1 RESERVED

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C-217.2 Discharge Planning

Each facility must maintain discharge planning procedures that describe the following:

- the staff member or the health, social or welfare agency responsible for discharge planning;
- the authority of the member or agency, and the methods used in discharge planning, including the relationship with the facility's;
- the time allowed for determining each resident's need for discharge planning. The period must not be longer than seven days after the day of admission;
- the period after which each resident's discharge plan will be re-evaluated;
- the local resources available to the facility, the resident, and the attending physician to assist in developing and implementing discharge plans; and
- the provisions for periodic review and re-evaluation of the facility's discharge planning program.

# Illinois Department of Public Aid

4(Keep Latest Copy)

LONG TERM CARE FACILITY NOTIFICATION

TO: FROM:

GENERAL INFORMATION

Client Name _____ Recipient Number _____ Case Number _____ SSN _____

Social Security Claim # _____ Birthdate _____ Print Name of Primary Attending Physician _____

1. ☐ ADMISSION: _____ Date
RECEIVE OR WILL RECEIVE HOSPICE SERVICE ☐ _____

From: Hospital ___ Community ___ SLF ___
DD Hospital ___ Other LTC Facility ___
_____
_____
Previous Address

2. ☐ DISCHARGE: _____ Date Community ___ Another Facility ___ Other Location Within Same Facility ___

3. ☐ DEATH: _____ Date IN FACILITY: YES ____ NO____ _____ Name of Person to Whom Body is Released Relationship

_____ Address City State Zip

4. ☐ COMPLETE THIS SECTION ONLY WHEN REPORTING A DISCHARGE OR DEATH.
___ Personal Funds Balance on the Day of Discharge or Death: _____
___ Amount of Other Funds on the Day of Discharge or Death: _____
___ Room & Board Balance on the Day of Discharge or Death: _____
___ Funds were Given to: Client ___ Relative ___ Administrator of Estate ___ Other _____
_____ Name/Relationship/Address _____ Amount

5. ☐ OTHER

A. ( ) Change in Income: Check as Appropriate.
___ Change in Income: Previous Monthly Amount_____ Date Last Rec'd. _____
Current Monthly Amount _____ Date First Rec'd. _____
Source _____
___ Receipt of Income: Mo. Amt. _____ Source _____ Date First Rec'd._____

Receipt of Lump Sum Payment: Amt. _____ Source _____ Date Rec'd._____

B. ( ) Medicare Covered SNF Services. Check as Appropriate.
___ Full Medicare Covered SNF Services: Begin Date _____ End Date _____
___ Medicare Coinsurance: Begin Date _____ End Date _____

C. ( ) Insurance Coverage (TPL) (e.g. change in coverage/change in premium) _____
_____

D. ( ) Receipt of Insurance (TPL) Payment
Date Received: _____ Amount:_____ Dates Covered by Payment: _____
Date and Amount of TPL Funds, if any, Returned to Client: Date _____ Amt. _____
Date and Amount of Group Care Credit Funds, if any, Returned to Client: Date _____ Amount_____

6. ☐ REMARKS: _____

DPA 26 Attached: Yes ____ No ____ DPA 2448 Attached: Yes ____ No ____ DPA 2536 Attached: Yes ____ No ____

Signature/Title _____ Date _____

Disclosure of information and/or compliance with instructions is mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code. Failure to comply may result in the Department taking unfavorable action.

# INSTRUCTIONS FOR COMPLETION

PURPOSE: The DPA 1156 is used by the LTC facility to notify the Group Care Worker of admission, discharge, death or other changes in circumstance of a client which could have an effect on continuing eligibility. When changes in the client's circumstances occur, this notice must be forwarded to the local office within five days of the change. Since reserve bed days do not affect eligibility, it is not necessary to complete this form to report absences for hospitalization or therapeutic home visits.

FORMS COMPLETION: The form is completed in duplicate with the original to the appropriate local office and the copy retained by the facility.

ITEM INSTRUCTIONS:

TO: Enter name of local office.

FROM: Enter facility name and address.

General Information: Self-explanatory.

1. Check if a new admission. Check other statement that applies. Enter date and previous address. If admitted from other than community, enter name of hospital or other facility on "previous address" line.

2. Check as appropriate. Enter date of discharge; name of facility, relative or self; relationship, if any; and address.

3. Check as appropriate. Enter all information for this item.

4. Do not delay submittal of this form because the client's funds have not been disbursed. Enter the balance of funds on the day of discharge or death. If none, enter "O". Enter name/relationship/address of persons to whom funds were given and the amount disbursed. Enter "O" if the funds have not been disbursed as of the date the form is completed.

5. This item is completed only upon receipt of information or as changes occur. Check as appropriate and enter necessary information.

6. Remarks Section is completed to convey additional information for which no other space is provided on the form; i.e., funds in excess of $2,000.00; or resident has not returned to facility following a period of reserve bed.

The form must be signed and dated by the person to whom the facility has assigned the responsibility for reporting status changes.